

REFUSAL TO CONSENT TO NEWBORN SCREENINGI/We, _____, the parent(s) of
Name of parent(s)_____, born on _____ at
Infant's name Date of birth_____, refuse to have blood taken from our child for the purpose of
Place of birth

determining if (s)he might have a metabolic or other disorder. The conditions tested for include the twenty-nine conditions listed below. It has been explained that the Vermont Department of Health recommends that all babies be tested for these conditions in the newborn period.

<i>3-Methylcrotonyl-CoA carboxylase deficiency (3MCC)</i>	<i>Maple syrup urine disease (MSUD)</i>
<i>3-OH 3-CH3 glutaric aciduria (HMG)</i>	<i>Medium-chain acyl-CoA dehydrogenase deficiency (MCAD)</i>
<i>Argininosuccinic acidemia (ASA)</i>	<i>Methylmalonic acidemia (Cbl A, B)</i>
<i>Beta-ketothiolase deficiency (BKT)</i>	<i>Methylmalonic acidemia (mutase deficiency) (MUT)</i>
<i>Biotinidase deficiency (BIOT)</i>	<i>Multiple carboxylase deficiency (MCD)</i>
<i>Carnitine uptake defect (CUD)</i>	<i>Phenylketonuria (PKU)</i>
<i>Citrullinemia (CIT)</i>	<i>Propionic acidemia (PROP)</i>
<i>Congenital adrenal hyperplasia (CAH)</i>	<i>Severe Combined Immunodeficiency (SCID)</i>
<i>Congenital hypothyroidism (HYPOTH)</i>	<i>Sickle cell anemia (SCA)</i>
<i>Cystic fibrosis (CF)</i>	<i>Trifunctional protein deficiency (TFP)</i>
<i>Galactosemia (GALT)</i>	<i>Tyrosinemia type I (TYR I)</i>
<i>Glutaric acidemia type I (GA I)</i>	<i>Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD)</i>
<i>Hb S/Beta-thalassemia (Hb S/Th)</i>	
<i>Hb S/C disease (Hb S/C)</i>	
<i>Homocystinuria (HCY)</i>	
<i>Isovaleric acidemia (IVA)</i>	
<i>Long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCHAD)</i>	

Other types of screening tests which can be done in the home or hospital include screening for hearing loss and pulse oximetry to screen for Critical Congenital Heart Disease.

~I/we have been informed that the procedure involves a heel stick to obtain blood for the test.

~I/we have had the opportunity to discuss newborn screening with our baby's doctor, the hospital nursing staff, or other care provider, and all our questions have been answered to our satisfaction.

~I/we further understand that if our baby does have one of these conditions and that if the condition is not diagnosed in the newborn period, the risk that our child could have health problems, including intellectual disabilities and/or death, could be very high.

~I/we acknowledge that this form will be filed in our baby's medical record, and copies will be sent to our baby's care provider and the Vermont Department of Health.

Signature of parent(s)_____
date_____
Signature of witness_____
date**Instructions:**

1. This form must be completed for all infants when the parent(s) refuse to allow newborn screening for their infant.
2. The original signed copy must be filed in the infant's hospital medical record or, in the case of home births, in the record kept by the birth attendant.
3. Photocopies should be sent to the infant's primary care physician and to the Vermont Newborn Screening Program, PO Box 70, 108 Cherry St., Burlington, VT 05402. Call (802) 951-5180 with questions.

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